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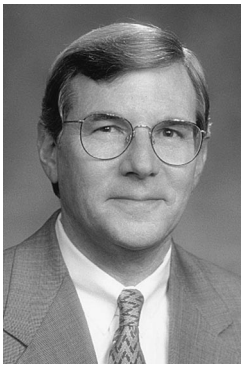

President's Page: First, Do No Harm

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This fundamental lesson of medicine has been learned by physicians for centuries and taught to subsequent generations of care givers. At its heart, it is a message of restraint and responsibility, caution and conscientious attention to the consequences of one's acts. We are all made better physicians by its simple yet unforgettable admonition.

It appears to be time for medicine to share this message with Congress and the administration: *first, do no harm*.

As previously communicated to all Fellows of the College by Dr. Richard Lewis, the proposed Medicare fee schedule (MFS) published by the Health Care Financing Administration (HCFA) in January of this year is aimed, ideally, at fairly reallocating the practice expense portion of the Medicare fee to more accurately reflect the comparative practice costs of physicians and others. Congress genuinely thought that a relative value system could correct traditional market inequities in reimbursement, and so in 1992 applied a relative value scale (RVS) to Medicare; it took further steps in 1994 to apply the concept to practice expenses—nonphysician work and nonprofessional liability costs—by directing HCFA to develop a resource-based system.

Well-intentioned members of Congress passed the legislation, and hard-working bureaucrats set about calculating the data. Now, however, behind schedule, and with a history of failed research and astonishingly poor data analysis, the HCFA proposes to publish final rules in May for implementation of the new RVS in January 1998. The harm that will be done is not confined to cardiology and cardiac surgery: thoracic surgery, neurosurgery, gastroenterology and other essential specialties will be hard hit by the consequences of these federal actions. The "harm" in our specialty alone amounts to 70% to 80% cuts in practice expenses and up to 44% of the full Medicare fee for certain cardiac surgical procedures. But the true harm is greater, as it would affect our ability to assure adequate access to well-managed care.

The reimbursement of professional services has been carved arbitrarily enough into three categories: physician work, practice expense and professional liability (medical malpractice insurance) costs. Liability costs are fairly easily established and measured; they remain fairly constant. Physician work has been assigned a relative value as a result of painstaking effort by the Physician Payment Review Commission (PPRC), the HCFA and our own research at the College. And as you know, valuing the practice expense component of the Medicare fee schedule has been a top priority for the College for a number of years.

While the College has systematically worked toward devising a reasonable approach to incorporating practice expense into the resource-based RVS, what the HCFA has proposed appears to be based on invalid and very poorly calculated data. The Lewin Group has critiqued the HCFA approach and has concluded that the proposed changes are out of line with reality, based on partial or incomplete data, the result of an inadequate methodology or simply the result of reliance on outdated information and are far too extreme.

At this point, we are working with the HCFA to help them step back and take a fresh approach to carrying out the congressional mandate. However, we have also made it clear to the agency that the four separate analyses that they have suggested all result in unacceptable figures: unacceptable as much for their lack of validity and relevance to our practice as to their potentially harmful effects.

Even as we are working with the HCFA and preparing a strong critique of their proposed rule, we are also pursuing a legislative strategy to assure that members of Congress fully appreciate the consequence of the RVS that they set in motion to achieve "fairness" in reimbursement. We know that it was not their intention to so arbitrarily take up to 80% of a key component of professional expenses from selected specialties, thereby compromising the abilities of specialists—and especially hospital-based specialists—to serve their patient populations professionally as well as clinically. Left uncorrected, the HCFA approach would be like expecting airline pilots to fly passengers coast to coast on a tenth of a tank of fuel—sure, it would save money . . . .

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Beyond the technical and legislative strategies, we are also exploring every legal avenue in the event that action is necessary. The regulatory proposals to date are so completely unacceptable that simple delay of implementation and a partial "fix" of the numbers would lead to such harm as to require a legal intervention. And we are prepared to coordinate our communications to federal officials with more broad-reaching communications as appropriate.

A large and committed coalition of medical organizations have come together, and this Practice Expense Coalition has already held an organizational summit in Washington, D.C., to plan coordination of activities. We are all dedicated to helping the federal government "get it right." We do not quarrel with Congress' desire to have specialty-specific resources recognized in reimbursement; we support the HCFA's normally sophisticated analysis of components of cost and wish to help them find a responsible set of implementation data in this instance. But we cannot tolerate an abusive, arbitrary and unscientific regulation recklessly thrown together to meet an equally arbitrary deadline.

As we explained to the Health Care Financing Administration,

> For six years, the ACC [American College of Cardiology] has been a part of the technical, methodological, and the sometimes political discussions surrounding the complex process of developing a resource-based practice expense component of the Medicare fee schedule (MFS). As part of this process, we certainly seek a fair solution to the problem of undervalued evaluation and management services. However, we do not believe the HCFA proposal represents such a solution.

We could not say it any more simply: first, do no harm. The College will work with responsible members of Congress to see that their original intent is realized when the HCFA finally submits a reasonable and workable plan to reallocate practice expense. We will then cooperate with HCFA to assure that implementation is smooth and accountable. We will do this because we have always worked to protect the interests of our patients and of our profession, interests that are invariably linked. Just as we remember the admonition each time we bring our expertise to bear in taking care of people, we must do no less in our dealings with the government.

I wish to acknowledge the assistance of Marie Michnich, DrPH, in preparing this commentary.